

TRICARE:

UNDERSTANDING

THE MILITARY'S

CHANGING HEALTH CARE SYSTEM

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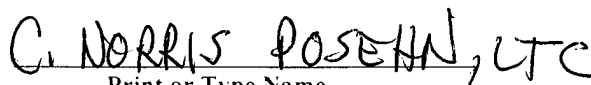
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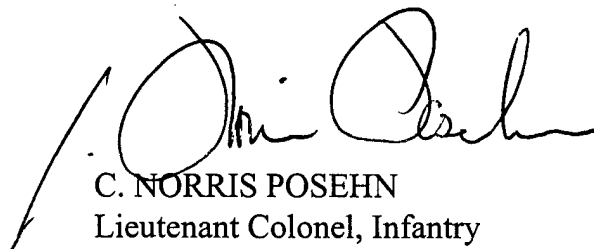
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Author's Comment:

This report was originally prepared in September, 1996, as a graduate research project. It constitutes a comprehensive academic study of the Department of Defense's health care system and explains how and why TRICARE emerged. My interest in this particular subject was predicated on the fact that I could not find a single source document that fully explained TRICARE.

Where appropriate, revisions have been made in this version to reflect the most up to date information and developments pertaining to TRICARE.



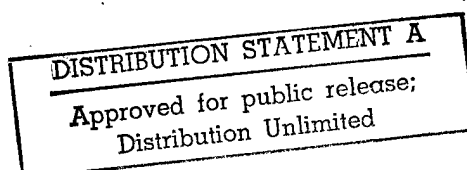
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"Things refuse to be mismanaged long."

--RALPH WALDO EMERSON



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THE MILITARY'S CHANGING HEALTH CARE SYSTEM

Thesis Statement

Following the national trend toward managed health care, military medicine is undergoing a total quality emphasized change to significantly improve everyday health care delivery while recognizing the need to ensure access to secure quality health care benefits, control costs, and respond to changing national military and health care priorities.

Introduction

The purpose of this research paper is to examine the background of how military medicine was available to beneficiaries in the past, significant changes in military health care, the current state of the Military Health Services System (MHSS), and a look at proposals for future changes and improvements.

One look at the headlines in newspapers across the nation will demonstrate that the cost of providing first rate health care has risen to a level which threatens to undermine our entire system. This is a fact in the civilian community and also presents a problem with which the military must contend. Adding to the military equation is the trend toward a drawdown of force strength and the shrinkage or closing of military health care facilities. Because of these developments, the Department of Defense (DoD) has been mandated by Congress to initiate broad based reforms in the military health care system which mirror, in many respects, the changes taking place in the private sector. These changes will presumably make health care services more accessible and easier to use, and will place the military on the cutting edge of health delivery in the 21st Century.¹

The long-established ways of providing medical care for military service members, military retirees, and family members are changing. The approach being taken by Congress and military leaders is that nothing is considered sacrosanct and everything is up for overhaul, provided it is practical and makes good sense and will result in a better way of providing health care. The bond with career service member beneficiaries for lifetime medical care--though not an entitlement in law--is being redefined. The historic promise of "free" lifetime medical care is coming face-to-face with the fiscal realities of the post-Cold War era.

During the Cold War, the Defense Department maintained a large medical infrastructure of personnel and facilities, providing health care for service members and their families and retirees on a space-available basis as a means to maintain medical skills and readiness. It also fulfilled what was perceived as a promise of continuing medical care to retirees. With the end of the Cold War, wartime requirements for medical care declined so dramatically that policy makers are now

¹ Almquist, Theodore C., Brigadier General, United States Army. "Message From The Lead Agent." Editorial. TRICARE Supplement. Gaithersburg, MD. 1996. 2.

faced with the question of whether to maintain a medical establishment that is far larger than needed to perform its primary mission.

In light of the resource-constrained military medical system, some elements within the DoD, the recent Commission on Roles and Missions of the Armed Forces (CORM), the General Accounting Office (GAO), and the Congressional Budget Office (CBO) have asked if the military medical departments should be providing peacetime health care to anyone other than active duty service members. Some would scale down medical department personnel by up to 50 percent, a level believed sufficient to provide peacetime soldier care and wartime casualty care. Additionally, military medical care facilities are currently being closed because of base closures and realignments and medical personnel spaces are being drastically reduced.

The Surgeons General of the military services have testified that if the military medical departments are cut to meet only wartime needs, the armed forces would have great difficulty recruiting and retaining physicians, including surgeons; nurses; physicians' assistants; technicians; and other specialists. What size military health care system is needed for military requirements is still being debated.²

From this introduction it should be apparent that military medical care, and health care in general, are in a state of transition. Any changes that are promulgated will affect the readiness of the medical departments of the armed forces and the more than eight million men, women, and children who are eligible for care. In response to the recommendation of the CORM, DoD is examining the twin missions of readiness and everyday health care delivery. At the same time, Congress is seeking ways to reduce health care costs in federal medical programs as part of the effort to reduce the federal budget deficit.

Background: Past Studies, Reports and Reform Efforts

Since 1947, there have been more than one dozen major studies of the MHSS organizational structure. Close to seventy-five percent of these studies recommended the maintenance of the current MHSS structure be coupled with increased coordination and cooperation among the services.³ These early efforts to centralize the three military medical departments have been fueled by the belief that centralization would enhance the effectiveness of military medical care, while at the same time eliminate duplication and increase coordination among the services. A brief overview and synopsis of these previous major studies and reform efforts are important in order to understand and appreciate the evolutionary process of health care reforms within the military:

1949: The First Hoover Commission. This commission recommended consolidation of all large-scale federal medical care and research activities into a United Medical Administration. Under the plan, one service would have had responsibility for all hospital and most outpatient

² Grady, John E. "Military Health Care In Transition." Defense Report. Association of The U.S. Army's Institute of Land Warfare. Arlington, VA. 1996.

³ Kearns III, W. Paul, Lieutenant Colonel, USAF, et al. Report on The Organizational Structure of The Military Health Services System. U.S. Air Force Report to Congress: House and Senate Committees on Armed Services. Washington, DC. GPO. 1986. 3.

services within a geographic area.⁴

1949: The Hawley Board. This was a committee on medical and health services of the armed forces established by the Secretary of Defense, James Forrestal. Over an 18-month period, the board examined three alternative organizational structures: (1) a unified medical service supporting all three military departments; (2) a single manager plan, under which one service would be responsible for military medicine in support of all services; and (3) separate but coordinated medical departments for each service. The board rejected a single medical service in any form, noting that:

“Separation of the medical services from the departments they serve and sustain...would greatly reduce the efficiency and effectiveness of the medical services in rendering medical support to the various departments and agencies of the National Military Establishment.”⁵

The Hawley Board recommended “effective coordination” and policy guidance at the Secretary of Defense level.

1949: The Armed Forces Medical Advisory Committee (Cooper Committee). This committee was formed to advise the Secretary of Defense on health and medical matters and concluded “the objectives of unification are highly desirable,” but “so much of the medical department...of each of the armed forces, should remain as integral parts of these forces.” The Cooper Committee recommended appointment of a full-time director general of medical services, responsible for controlling policy standards, programs, and administration. A Medical Services Division of the Office of The Secretary of Defense (OSD), a forerunner of the Office of The Assistant Secretary of Defense for Health Affairs (OASD(HA)), was established in July 1949 as a result of this recommendation.⁶

1955: The Second Hoover Commission. This commission summarized its conclusions of military health services by stating that “...in the absence of unification, regionalization can offer the best solution.” However, the commission did not recommend unification, presumably because it was not considered feasible.⁷

1958: The Collier Report. This report was prepared in response to President Eisenhower’s request that Dr. Collier, a non-DoD physician, determine if it would be advantageous to designate one service as the single manager for military health services. Dr. Collier’s report is frequently cited to support the current system of three separate but coordinated medical departments. It basically described and supported the status quo.⁸

1966: The Comprehensive Medical Services Program Review. This review addressed the

⁴ Rice, Donald B. Defense Resource Management Study, Supporting Papers: Military Health Care. Washington, DC. GPO. February 1979. 175-183.

⁵ Rice 175.

⁶ Rice 175.

⁷ Rice 176.

⁸ Rice 176.

feasibility and desirability of unification of the medical services of the armed forces and/or establishment of a defense medical agency. The military departments responded by supporting the current system of three separate medical departments. Although an associated staff paper outlined possible economies of unification, the OSD rejected the staff paper because it was not based on a comprehensive analysis of the current system and failed to prove that claimed effects would outweigh the certain near term turbulence.⁹

1968: Clifford/Nitze Report. Special Assistant to the President, Joseph Califano, asked the Secretary of Defense, Clark Clifford, for his views on unification of military health services. The Deputy Secretary of Defense, Paul Nitze, responded that unification was neither desirable nor feasible because: (1) many common medical functions were already consolidated; and (2) a substantial and critical portion of each medical service was closely integrated with the force it supported, and that as long as the services maintained their separate identities, unification was not realistic.¹⁰

1972: DoD/HEW Study on Reducing Needs for Military Medical Personnel in the Armed Forces. This study did not deal directly with the organizational structure of the MHSS, however, two of its major recommendations were related to the organizational structure: (1) peacetime health services support should be regionalized on a tri-service basis; and (2) military health care facilities should be partially staffed with civilian health professionals on a contractual basis. To a limited extent, both recommendations were implemented.¹¹

1975: DoD/HEW/OMB Military Health Care Study. This major study was undertaken at the direction of the President and reviewed the mission and objectives of the MHSS and made extensive findings. In general, the study determined that the MHSS provides a broad spectrum of relatively effective and efficient health care services to more than nine million entitled beneficiaries. In addition, the study demonstrated the unique capability of the MHSS to respond to military and civil emergencies. The study concluded, however, that a number of opportunities exist to improve MHSS efficiency and effectiveness while maintaining the delivery of quality care to entitled beneficiaries. Specific recommendations relative to organizational structure and processes were: (1) a central entity within DoD, serving as a coordinating mechanism for planning and allocating resources, should be established to oversee health care delivery in the Continental United States (CONUS); (2) oversight of health care delivery operations should be assigned to regional authorities responsible for all health care delivery in their CONUS geographic areas; (3) resource programming and budgeting for the MHSS in CONUS should be done on a capitation basis; and (4) resource programming for the direct care system and the Civilian Health and Medical Program of The Uniformed Services (CHAMPUS) should be integrated within DoD.¹²

1979: Defense Resource Management Study (Rice Report). This study was requested by the President and commissioned by the Secretary of Defense. The Rice Report was a searching organizational review into five broad areas of resource management, one of which was the MHSS.

⁹ Rice 177.

¹⁰ Rice 177.

¹¹ Rice 178.

¹² Rice 178.

The study's conclusions regarding the organizational structure of MHSS stated:

"It is difficult to show that either regional commanders or a central DoD agency would substantially improve the efficiency or effectiveness of the health care system, or to show that they would not."¹³

The Rice Report went on to note:

"...With the readiness mission primarily in mind, the current decentralized system, more closely linked to the deploying forces, seems better. With the realization that desirable objectives can often conflict, the Defense Resource Management Study opts for a more concerted effort to pursue both missions (peacetime and wartime) through the current, decentralized system."¹⁴

1983: President's Private Sector Survey on Cost Control (Grace Commission). The Grace Commission recommended that DoD pursue legislative authority to create a central health entity within OSD to consolidate many of the services available in the MHSS and more effectively plan the efficient delivery of health care.¹⁵ The report further stated that such an organizational change would continue to recognize the characteristic needs of each armed service's medical system but would place overall authority for the planning and operation of such systems in the central health entity.¹⁶

1983: Report for the Secretary of Defense on the Feasibility and Benefits to be Gained From Creating a Defense Health Agency (DHA). The Senate Armed Services Committee directed the Secretary of Defense to study the feasibility of and benefits to be gained by creating a Defense Health Agency. This study concluded that: (1) medical mobilization is a critical problem; (2) there are realistic opportunities to contain military health care costs; (3) quality of military peacetime health care is at least comparable to that received in the civilian sector; (4) maintaining high quality care should be pursued vigorously in conjunction with improvements in mobilization and cost containment; (5) medical readiness would be improved if the services' surgeons general focused on mobilization needs; (6) a single manager for all fixed facilities would provide savings in management personnel; (7) integration of the peacetime health programs of the services and CHAMPUS and other efficiencies integrations could result in significant economies; and (8) creation of a DHA is feasible, though some obstacles will need to be surmounted.

The conclusions of this study were opposed by the military departments and the Joint Chiefs of Staff (JCS). The military departments opposed the recommended change, which would shift numerous major functions, thousands of people, and billions of dollars to a new defense agency that would not be under their control. Military leaders, through both the JCS and services'

¹³ Rice, Donald B. Defense Resource Management Study - Final Report. Washington, DC. GPO. February 1979. 111.

¹⁴ Rice, Defense Resource Management Study - Final Report 111.

¹⁵ President's Private Sector Survey on Cost Control. Task Force Report on Federal Hospital Management. 13 June 1983. 12.

¹⁶ President's Private Sector Survey on Cost Control 79.

secretariat channels, questioned the need for change, raised potential problems that the DHA would face, and suggested other solutions to improve health care management short of creating the DHA. In their judgement, the DHA was not feasible because: (1) the DHA would create management problems, especially during mobilization; (2) most of the savings cited in the DHA study could be achieved without reorganization; and (3) the current coordinating mechanisms could accomplish the goals of a DHA.¹⁷

In 1985, Congressmen Ralph Regula and Claude Pepper introduced House of Representatives (HR) Bill 1136 before the 99th Congress during its first session in an attempt to consolidate the medical health care system of the armed services to be administered in policy and operation solely under the auspices of a newly formed Defense Health Agency. Had this legislation been implemented, it would have created a single agency responsible for overseeing the services' health care delivery system.¹⁸

1985: Blue Ribbon Panel on Sizing DoD Medical Treatment Facilities. In 1984, the Assistant Secretary of Defense for Health Affairs (ASD(HA)) established a Blue Ribbon Panel of civilian health care experts to review the criteria for sizing military medical treatment facilities and to determine if expanded use of available civilian facilities could be cost-effective. The panel made six principal recommendations: (1) medical readiness requirements should be the primary criterion for determining the size and composition of the peacetime active duty medical force and of the facilities in the direct-care system; (2) permit more realistic and rigorous analysis of the appropriate size of specific facilities. Current estimates of wartime requirements should be further refined and the management information systems now under development should be completed and implemented without delay; (3) the review of DoD medical treatment facilities and the selection of candidates for funding as medical military construction projects should be consolidated and streamlined so that all facilities are reviewed by the OASD(HA). The OASD(HA) will be responsible for selecting those facilities most urgently needing replacement, modification, or modernization and for allocating resources to those projects; (4) the interval between the final determination of the appropriate size for a medical facility and the construction of that facility is currently too long, resulting in facility construction based on outdated analysis. A final review of facility requirements should precede initiation of construction by no more than two years; (5) firm guidelines should be developed to ensure when it is consistent with the readiness mission and cost effective to do so, the MHSS should make use of civilian or other governmental (e.g., Veterans Administration) capabilities to provide care to its beneficiaries; and (6) the MHSS must adopt workload measurements and other resource allocation mechanisms that reward the cost-effective provision of quality care and eliminate incentives for overutilization of services.¹⁹

In October 1984, DoD Directive 5136.1, the ASD(HA)'s charter, was revised and

¹⁷ Hunter, Richard W. and Benjamin R. Baker. Report For The Secretary of Defense on The Feasibility and Benefits to be Gained From Creating The Defense Health Agency. Contractor No. MDA-83-C-0082. Systems Research and Applications Corporation and Delphic Concepts, Inc. Arlington, VA. 26 August 1983. 7-1 and 7-2.

¹⁸ U.S. House of Representatives Bill 1136. 99th Congress. 1st Session. GPO. February 1985.

¹⁹ Blue Ribbon Panel on Sizing Department of Defense Medical Treatment Facilities. Final Report. 28 June 1985.

significantly strengthened to recognize the ASD(HA)'s authority for overall supervision of DoD health affairs and to serve as program manager for DoD health and medical resources. The extent of the ASD(HA)'s control of the MHSS was further increased by recommendations of the 1985 Blue Ribbon Panel.²⁰

The 1986 Defense Authorization Act directed the Secretary of Defense to submit to the Congress a report prepared by the ASD(HA) on the *Organizational Structure of the Military Health-Care Delivery System*. The report was to be the result of independent studies conducted by the Secretaries of the Army, Navy, and Air Force, and the JCS. The following specific areas of inquiry were to be addressed: (1) *Streamline Resource Allocation*; (2) *Improve Quality of Medical Care*; (3) *Reduce Health Care Cost*; and (4) *Enhance Medical Readiness*.²¹

After a review of the MHSS performance in achieving the four goals listed above, and the MHSS organizational changes which transferred responsibilities from the services to the OASD(HA), the report concluded that the MHSS did not require any major organizational change. In addressing each of the four specific goals established by the Congress, the response concluded the following: (1) *Streamline Resource Allocation*. Efforts to change the MHSS resource allocation process by removing resource control and allocation decisions from the military departments are not consistent with DoD Planning, Programming, and Budgeting System process or the command and control structure; (2) *Improve Quality of Medical Care*. Recent and ongoing service and DoD initiatives to improve the quality of care are substantial and positive results are being achieved; (3) *Reduce Health Care Cost*. Substantial reductions in DoD health care costs have occurred through cooperation and resource sharing efforts among the services' medical departments and between DoD medical activities and the Veterans Administration. Current plans to replace the existing CHAMPUS program with national contractors who would be at risk for health care provided outside the direct care system could affect both medical readiness and the structure of the MHSS; and (4) *Enhance Medical Readiness*. Significant progress has been made in enhancing medical readiness, especially in the areas of joint planning, training, and prepositioning of medical assemblages overseas. Planning efforts within CONUS must now address issues such as anticipated patient mix for treatment, required location of specialty centers, and the proper mix of providers and support personnel.²²

In May 1994, the ASD(HA) charter was further strengthened and delineated the ASD(HA) as the specific DoD official responsible for the execution of the Department's health care mission. In carrying out these responsibilities, the ASD(HA) exercises authority, direction, and control over medical personnel, facilities, programs, funding, and other resources within DoD to include serving as the program manager for the Defense Health Program.²³

²⁰ Blue Ribbon Panel on Sizing Department of Defense Medical Treatment Facilities. *Final Report*. Cited by Lt Col Paul W. Kearns, et al. *Report on The Organizational Structure of The Military Health Services System*. U.S. Air Force Report to Congress. Washington, DC. GPO. 1986. 3.

²¹ U.S. Senate. Committee of Conference Report. "1986 Department of Defense Authorization Act." 99th Congress. 1st Session. Report #99-118. Section 1207. Washington, DC. GPO.

²² Kearns 5-8.

²³ The Defense Health Program is the umbrella title used in the Congressional budget to address the formal health care line item for DoD. The program manager of this \$15.2 billion dollar budget is the ASD(HA).

Health Care Reform: Situation Analysis

National Health Care

A complete analysis of the potential impact of national health care reform is beyond the scope of this paper. However, a cursory overview of the current national health care situation is relevant to understanding the correlation between the Military Health Services System which reflects the general problems inherent within the civilian health care system nationwide.

Although the United States is generally regarded as having the world's best medical care, the system is beset with problems of limited access to quality care and skyrocketing costs, currently approaching \$1 trillion per year. If the current system continues as is, the total amount spent on health care is predicted to more than double to \$2.1 trillion in 2003, or an estimated 20 percent of the gross domestic product. By this time, the average family will be spending 18 cents of every dollar for health care, double the amount spent in 1980. High cost is a major issue in the national debate over reforming U.S. health care. Although 85 percent, or 215 million, of Americans have health insurance coverage, more than 37 million Americans go without health coverage at some point each year. Another 20 million are considered underinsured. Those without health coverage frequently seek non-emergency health care in hospital emergency rooms, a less than cost-effective process. Ultimately, the cost of this care is passed on through increased charges to those with health insurance, a practice known as "cost-shifting."²⁴

One of the major, overriding reasons for higher health care spending arises from government subsidies, tax policies, and regulations. In fact, government spending accounted for 42.2 percent of total health care spending in 1990.²⁵ Because of tax advantages, employers have provided employer-based health insurance with low copayments and low deductibles. This has created a marketplace where individual consumers usually do not spend their own money; consequently they have no disincentives to overuse medical services and no incentive to "comparison-shop." In today's marketplace, providers are free to over-serve and overcharge for their services.²⁶

Structure of the Current Military Health Care System: Challenges and Complexities

Health care for military beneficiaries, primarily active duty and retired personnel plus their dependents, is provided through a dual system. The Army, Navy, and Air Force operate 124 hospitals and 504 clinics, referred to as MTFs, throughout the world. This "direct care" system is augmented by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), a DoD administered health insurance program that finances civilian care for active duty

²⁴ Principles and Recommendations for Health Care Reform. The Retired Officers Association (TROA). Alexandria, VA. 1993. 5-7.

²⁵ Wasley, T. P. "What Has Government Done to Our Health Care?" CATO Institute. Washington, DC. 1992. 8. Cited by TROA. 1993. 5-7.

²⁶ Bast, Rue, and Wesbury. "Why We Spend Too Much on Health Care." The Heartland Institute. 1992. 15. Cited by TROA. 1993. 7.

dependents, retirees, and retirees' dependents below the age of 65.²⁷ Together, the direct care system and CHAMPUS are known as the Military Health Services System (MHSS). Most direct care services are free to the beneficiary, while CHAMPUS generally charges a deductible and copayments of 20 to 25 percent. Of the nine million military beneficiaries, about six million are eligible for CHAMPUS. (See Appendix A: Profile of U.S. Medical Treatment Facilities, Community Hospitals, and Beneficiaries).

The MHSS provides health care to roughly 8.2 million beneficiaries, including active duty military personnel and their dependents, retired military personnel and their dependents, and survivors of military personnel. In addition, the MHSS provides health care for National Guard and Reserve members serving on active duty (and their families), civilian employees at selected DoD facilities, and other beneficiaries of government health care. The DoD medical system is staffed by about 200,000 active military and civilian personnel and over 200,000 reserve personnel. The annual cost for this care is in excess of \$15 billion, representing about 6 percent of the total defense budget.²⁸

The primary mission of the MHSS is to maintain the health of 1.7 million active duty service personnel,²⁹ including delivery of health care during times of war. Also, as an employer, DoD offers health care services to 6.6 million nonactive duty beneficiaries who comprise almost 80 percent of the people eligible for military health care. These services are provided by MTFs and CHAMPUS. Of the approximately \$15.2 billion budgeted for the MHSS in fiscal year 1995, the CHAMPUS share was nearly \$3.6 billion or about 24 percent. MHSS costs continues to rise at an annual rate of 8.2 percent.³⁰

Despite the military drawdown, the demand by beneficiaries for care will remain high, largely because of continued growth in the population of military retirees and their dependents and survivors. DoD projects that its total population of beneficiaries will decline between 1989 and 1999 by only about 9 percent, despite a reduction of 27 percent in the number of active duty members and their dependents who are eligible for care. By 1999, more than 8 million people will remain eligible to receive care through the military health system, and retirees and their families will make up a larger share--over 50 percent--than ever before.³¹

In principle, DoD could separate its responsibility to provide beneficiaries with access to medical care from its direct provision of care in military facilities. Given that DoD reimburses beneficiaries for care received from civilian providers, it already makes that separation. If the

²⁷ Active duty personnel and beneficiaries age 65 or over are not eligible for CHAMPUS. They receive all their health care through military facilities and Medicare replaces CHAMPUS at age 65.

²⁸ Lanier, Jack O. and Charles Boone. "Restructuring Military Health Care: The Winds of Change Grow Stronger." Hospital & Health Services Administration. Vol 38. No. 1. Spring 1993. 121-132. Cited by Mark J. Perry. For Better or Worse, In Sickness and In Health. Diss. RAND Graduate School. 1995. Published by RAND. 1996. 1.

²⁹ Includes members of the Coast Guard and the Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration who are also eligible for military health care. Cited in GAO Rpt HEHS-95-104. Issues and Challenges Confronting Military Medicine. Washington, DC. GAO. March 1995.

³⁰ Defense Health Care: Despite TRICARE Procurement Improvements, Problems Remain. Washington, DC. GAO/HEHS-95-142. August 1995. 3-4.

³¹ Davidson, Ellen Breslin. Restructuring Military Medical Care. Congressional Budget Office Papers. CBO. Washington, DC. July 1995. 3.

direct care system were downsized and a larger share of remaining medical resources focused on training for wartime, DoD might have to rely primarily on the private sector for peacetime care. However, substantial opposition exists to the notion that the wartime mission can be separated from the direct provision of care to civilian beneficiaries. Military medical officials contend that reducing facilities and staffing could seriously jeopardize wartime readiness. In their view, military medical facilities and the care those facilities provide in peacetime are essential to train physicians and ensure medical readiness for wartime. In addition, the officials claim they must support a large enough training base to attract, recruit, and retain medical personnel and sustain a core of medical leaders.³²

In response to pressures from the Congress and beneficiary groups, DoD has developed plans to reform its provision of peacetime health care while maintaining wartime readiness. The Department's plan, known as TRICARE emphasizes improving the performance of the peacetime health care system. In the face of diminishing wartime requirements, retaining the current military medical establishment can be justified only if two conditions are present: first, the provision of peacetime care must contribute to the ability of DoD to perform the wartime mission; and second, the Department must be able to provide peacetime health care cost-effectively.

The statutory entitlement for military health care is contained in Chapter 55, Title 10, U.S.C. Prior to 1965, the statutory language regulating the provision of military medical care did not specifically address care for military retirees. Public Law (P.L.) 84-569 (70 Statute 250, June 1956) established initially by the Dependents' Medical Care Act of 1956, states that active duty members are entitled to health care while their dependents are entitled to care in MTFs on a space-available basis. Furthermore, the law states that retirees and their dependents may receive care in MTFs on a space- or service-available basis. According to a report by the Congressional Research Service,³³ Congress recognized that: (1) military retirees were not able to access MTFs because of space limitations, lack of available services, or travel considerations; (2) retirees had retired at an age long before they would become eligible for Medicare; and (3) retirees were at a comparative disadvantage in terms of available health care relative to federal civilian workers. Accordingly, on 30 September 1966, Congress created CHAMPUS for nonactive duty beneficiaries by enacting P.L. 89-614 (80 Statute 862), Military Medical Benefits Amendments.

Today, as during the Cold War, a significant major military operation or war would necessarily require that priority for medical care be primarily for service members. Unless other actions were taken by DoD, families and retirees would have to rely exclusively on CHAMPUS or the new TRICARE system.

The first real test of this wartime scenario occurred during Operation Desert Shield/Desert Storm. Whether in recognition of the commitment made to family members and retirees or because of the enormous expense and impact on the CHAMPUS system, DoD decided not to rely on CHAMPUS when military doctors went to Desert Storm. Instead, reserve component doctors were called to active duty, in many cases not to serve with their reserve units, but to backfill at

³² Davidson 3.

³³ Burrelli, D. F. "Military Retiree Health Care: Base Closures and Realignment." Congressional Research Service Report for Congress. 21 September 1992. 2-3. Cited by TROA. 1993. 15.

active duty military treatment facilities.

A series of reforms, beginning with the Catchment Area Management (CAM)³⁴ demonstrations, was attempted in the 1980s at five sites located in Oklahoma, Colorado, Arizona, Texas, and South Carolina. Under CAM, Army, Navy, and Air Force hospital commanders could take CHAMPUS money and use it to treat patients within a forty-mile radius of military medical facilities, recapturing medical treatment cared for off-post, such as obstetrics, gynecology, and mental health. Emphasis was on the MTF commander to make sound clinical and business decisions instead of relying upon a civilian contractor. Within the CAM, the MTF commander managed all DoD health resources in his or her catchment area, including CHAMPUS funds.³⁵ When care could not be provided in the MTF, beneficiaries were given the names of doctors who would provide the necessary care at a discount to the patient and the military.³⁶ The objective of the CAM demonstrations was to pursue alternate delivery methods, voluntary enrollment, and Health Care Finders features.

Another method initiated in 1985 by DoD to increase access to the military health care services and contain costs involved the establishment of the Primary Care for the Uniformed Services (PRIMUS) program, managed by the Army and Air Force, and the Navy Cares (NAVCARE) program, managed by the Navy. This care is available at clinics throughout the United States in an effort to maximize use of existing MTFs capacity and to allow more beneficiaries access to free care in the MTFs. These primary care clinics are staffed and operated by civilian contractors, but are considered an extension of the direct-care system providing care to all eligible DoD beneficiaries free of charge. PRIMUS and NAVCARE clinics are positioned near heavily used military hospitals to augment the delivery of routine ambulatory health care services and relieve overcrowding. These walk-in clinics are located in off-post neighborhoods and treat minor ailments and injuries, provide immunizations, and conduct patient medical examinations. Beneficiaries from all the services can use any of the clinics at no charge. In 1992, DoD placed a moratorium on further expansion of these clinics, pending review.³⁷

Over the years, the basic CHAMPUS fee-for-service program has added coverages (types of treatment and cost ceilings). Cost-sharing (the amount for which an individual was responsible after CHAMPUS paid its share) has remained the same for outpatient care and increased for inpatient care, and deductibility (out-of-pocket expenses a person had to pay before CHAMPUS would begin its coverage) has increased. Costs have risen and there has been a major operating shift in the way bills were paid by DoD.

Because of escalating costs, claims paperwork demands, and general beneficiary dissatisfaction with congressional authority, DoD initiated another demonstration project designed to test the feasibility of more effectively containing costs and improving services to beneficiaries.

³⁴ Catchment areas are geographic collections of zip codes forming a roughly 40-mile radius around each military hospital. Also referred to as a Health Service Area.

³⁵ Hosek, Susan D. The CHAMPUS Reform Initiative: Implications for Military Health Care Reform. RAND Congressional Testimony. RAND National Defense Research Institute. Santa Monica, CA. May 1993. 8.

³⁶ Grady, John E., John M. Molino, Veronica Zearley, et al. State of The Military Health Care System. Association of The United States Army's Institute of Land Warfare. Arlington, VA. January 1966. 2-3.

³⁷ Principles and Recommendations for Health Care Reform 17.

The CHAMPUS Reform Initiative (CRI), the most direct forerunner of TRICARE, introduced the concept of managed care into CHAMPUS. This was a plan to transform military health care into a system of managed care similar to that provided by health maintenance organizations (HMOs) in the civilian community. Included as part of a triple-option health benefit were a HMO, a preferred provider choice, and the existing Standard CHAMPUS choice. Managed care features introduced included enrollment, utilization management,³⁸ assistance in referral to the most cost-effective providers, and reduced paperwork. The first CRI covered California and Hawaii and was conducted between August 1988 and January 1994, when about 850,000 CHAMPUS beneficiaries were living in these two states.³⁹

In fiscal year 1987, the year before CRI was implemented, CHAMPUS spent almost \$2 billion to cover care received in the civilian sector. Between 1970 and 1987, costs rose at an average annual rate of 12.5 percent. CHAMPUS costs more than tripled from \$1.2 billion in FY 1984 to an estimated \$3.9 billion in FY 1994. The growing costs of the program, together with its other perceived problems of beneficiary dissatisfaction and lack of coordination with the direct-care system, led to the formulation of the CRI.⁴⁰

The CRI was one of the first to introduce managed care features to the CHAMPUS program. Beneficiaries under CRI were offered three choices: (1) a Health Maintenance Organization (HMO)-like option called CHAMPUS Prime that required enrollment and offered enhanced benefits and low-cost shares; (2) a preferred provider organization-like option called CHAMPUS Extra that required use of network providers in exchange for lower cost shares; and (3) the Standard CHAMPUS option that continued the freedom of choice in selecting providers and higher cost shares and deductibles. Other features of CRI included use of Health Care Finders (HCF) for referrals and the application of utilization management.⁴¹

To achieve its goals, the CRI had to successfully employ several innovative health care management techniques. The design of the program included the following features: (1) an enrollment program similar to a HMO, called CHAMPUS Prime; (2) availability of medical care at a lower cost through networks of civilian physicians and hospitals similar to a Preferred Provider Organization (PPO),⁴² called CHAMPUS Extra; (3) a Health Care Finder (HCF) service; (4) a resource-sharing agreement between the civilian contractor and the military hospitals; and (5) Quality Assurance (QA) and Utilization Review (UR) programs. In addition to the new health care options offered under CRI, CHAMPUS Prime and CHAMPUS Extra beneficiaries could choose to continue using their Standard CHAMPUS benefits.⁴³

CHAMPUS Prime (CRI's HMO) was a health care program in which CHAMPUS

³⁸ Utilization management involves the use of such techniques as preadmission hospital certification, concurrent and retrospective reviews, and case management to determine the appropriateness, timeliness, and medical necessity of an individual's care.

³⁹ Despite TRICARE Procurement Improvements, Problems Remain 4.

⁴⁰ Sloss, Elizabeth M. and Susan D. Hosek. Evaluation of The CHAMPUS Reform Initiative: Volume 2, Beneficiary Access and Satisfaction. RAND National Defense Research Institute. Santa Monica, CA. 1993. 2.

⁴¹ Despite TRICARE Procurement Improvements, Problems Remain 24-25.

⁴² A Preferred Provider Organization is a group of medical care providers who have signed an agreement with an insurer to provide care at a discounted rate for patients covered by the insurer.

⁴³ Sloss 4-4.

beneficiaries voluntarily enrolled. Once enrolled, they were required to remain enrolled for at least one year, unless they moved out of the designated area. CHAMPUS Prime enrollees were required to obtain all of their civilian care from provider networks (physicians and hospitals) established by the contractor, but they could continue to use military care as they did before enrolling. CHAMPUS Prime covered most preventive care services, such as routine physical exams; Standard CHAMPUS did not cover such services. In addition, members did not file claims for payment of their care; providers handled all claim-related paperwork.⁴⁴

The financial benefits of joining CHAMPUS Prime were significant. CHAMPUS Prime members paid only \$5 per visit for all primary care and most other outpatient care. In 1988, this compared favorably with the Standard CHAMPUS annual deductible for outpatient care of \$50 per person and \$100 per family and a cost-sharing payment of 20 percent (active duty families) or 25 percent (retiree families) for the cost of outpatient care above the deductible. When inpatient care was not available in the military hospital, members were admitted to civilian hospitals. The cost of civilian inpatient care for CHAMPUS Prime members was also much lower than under Standard CHAMPUS. For active duty dependents who were members of CHAMPUS Prime, there was no copayment for inpatient care. This was a slight improvement over the nominal \$25 per stay or \$7.85 per day (whichever was higher) copayment for inpatient care made by active duty dependents covered by Standard CHAMPUS. Retirees and their dependents who were CHAMPUS Prime members accrued substantial savings for inpatient care--they paid \$75 per day, up to maximum of \$750 per admission. Retirees covered by Standard CHAMPUS in 1988 would have paid \$175 per day, or 25 percent of the billed charges, whichever was less.⁴⁵

Starting in 1991, the option to enroll in CHAMPUS Prime was available in 17 MTF catchment areas in California and one in Hawaii. Enrollment was popular with beneficiaries, increasing steadily from the time the program started in 1988. In January 1992, more than 155,000 beneficiaries were enrolled in CHAMPUS Prime, representing 23 percent of the eligible population in the catchment areas offering CHAMPUS Prime. This level of enrollment compares favorably with the proportion of the general U.S. population enrolled in HMOs.⁴⁶

CHAMPUS Extra (CRI's PPO) was an option under CRI that was structured like a PPO. It offered improved benefits to CHAMPUS beneficiaries who used selected civilian providers, but did not require enrollment. One benefit offered to patients who used a CHAMPUS Extra provider was that they did not have to file a claim for payment of their care. The annual deductible remained the same as under Standard CHAMPUS coverage, but the copayment for outpatient care was lower if the patient chose a CHAMPUS Extra provider. The lower copayment for outpatient care from a network provider was 15 percent for active duty families (compared to 20 percent under 1988 Standard CHAMPUS). Copayments for inpatient care in a network hospital were waived for active-duty dependents and were lower for retirees, \$125 per day (compared to \$175

⁴⁴ Sloss 5.

⁴⁵ Sloss 5-6.

⁴⁶ Sloss 6.

per day under 1988 Standard CHAMPUS).⁴⁷

A Health Care Finder (HCF) was used in the CRI as a referral service to direct the flow of health care traffic in the most cost-efficient way. CHAMPUS beneficiaries were encouraged to contact the HCF when deciding what kind of care they needed and where to find it. The CRI HCF office referred CHAMPUS patients to an appropriate military or civilian provider and handled referrals for specialty care. Referrals to specialists for CHAMPUS Prime enrollees were always handled by the HCF. Every military hospital catchment area participating in CRI had a HCF service, as well as most of the large free-standing clinics. Most HCF offices were located within the MTF and were staffed by trained civilian personnel employed by the civilian contractor.⁴⁸

The results of studies addressing the CRI indicate that beneficiaries in CHAMPUS Prime experienced better access to and higher satisfaction with medical care during the CRI demonstration period than beneficiaries in control sites. Beneficiaries who enrolled in CHAMPUS Prime felt that the new program was "a step in the right direction" in terms of improving their CHAMPUS benefits.

Overall, the demonstration area was atypical of the rest of the Continental United States. For example,

- The demonstration area was more medically served than the other states. California and Hawaii had about 10 percent more nonfederal hospitals and 17 percent more physicians per capita than other states.
- CHAMPUS inpatient day costs were 17 percent higher in the demonstration area, though outpatient costs were much the same.
- CHAMPUS inpatient utilization was lower in the demonstration area while outpatient use was about 25 percent higher. This pattern could be related to the historical emphasis on managed care in the demonstration area. Thirty-one percent of the total population in the demonstration area was enrolled in HMOs, compared with 12 percent elsewhere.
- More resources were available to MTFs in the demonstration area: A higher percentage of MTF beds (71 percent versus 50 percent elsewhere) were in medical centers, and there were more uniformed care givers. Also, the 11 demonstration sites had newer facilities on the average than the control sites in other states.⁴⁹

In 1992 Congress again recognized its commitment to provide health care to members and former members of the uniformed services, and their dependents and survivors in a "Sense of Congress" resolution contained in Section 726, National Defense Authorization Act for FY 93 (P.L. 102-484). This resolution addressed the need for a comprehensive managed care plan and stated that active duty personnel should continue to receive *free care* in MTFs and their dependents, retirees, and survivors should receive health care at *reasonable* cost to the recipient of

⁴⁷ Sloss 6-7.

⁴⁸ Sloss 7.

⁴⁹ Anderson, Mary E. and Susan D. Hosek. Evaluation of The CHAMPUS Reform Initiative, Volume 6. Implementation and Operations. RAND National Defense Research Institute. Santa Monica, CA. 1994. 13.

the care.⁵⁰ Some military personnel and former military personnel maintain they and their dependents were promised "free medical care for life" at the time of their enlistment. Such promises have in fact been made by military recruiters and in recruiting brochures, but they were not based upon laws or official regulations which provide only for *access* to military medical facilities for non-active duty personnel *if space is available*. Space may not be available and CHAMPUS care can involve significant costs to beneficiaries. Rear Admiral Harold M. Koenig, the Deputy Assistant Secretary of Defense for Health Affairs, testified in May 1993:

"We have a medical care program for life for our beneficiaries, and it is pretty well defined in the law. That easily gets interpreted to, or reinterpreted into, free medical care for the rest of your life. That is a pretty easy transition for people to make in their thinking, and it is pervasive. We [DoD] spend an incredible amount of effort trying to re-educate people that is not their benefit."⁵¹

Another dimension of the health care equation that must be considered in order to better understand the complexities of the military health care program is that of Medicare. Active duty military personnel have been fully covered by Social Security and have paid Social Security taxes since 1 January 1957. Social Security coverage includes eligibility for health care coverage under Medicare at age 65. It was the legislative intent of the Congress that retired members of the uniformed services and their eligible dependents be provided with medical care after they retire from the military, usually between their late-30s and mid-40s. CHAMPUS was intended to supplement--not to replace--military health care. Likewise, Congress did not intend that CHAMPUS should replace Medicare as a supplemental benefit to military health care. For this reason, retirees become ineligible to receive CHAMPUS benefits when at age 65 they become eligible for Medicare. However, military retirees continue to be eligible for health care in military medical care facilities irrespective of age. Disabled persons under 65 who are entitled to Medicare may continue to receive CHAMPUS benefits as a second payer to Medicare, with some restrictions.⁵²

The experience from both the CAM and CRI demonstrations was incorporated into the Comprehensive Study of the Military Health Care System, which was requested in Section 733 of the National Defense Authorization Act for Fiscal Years 1992 and 1993. The study, commonly referred to as the "733 Study," estimated that DoD had potentially twice the number of physicians needed to meet wartime requirements. Although the services have not disagreed with the 733 Study results, their individual estimates produced higher numbers of physicians needed during peacetime to ensure wartime readiness. Theater commanders utilized different planning factors that resulted in higher estimates of casualties and relied more on the MHSS to treat patients

⁵⁰ Principles and Recommendations for Health Care Reform 13 and Appendix C.

⁵¹ U.S. House of Representatives. Committee on Armed Services. Military Forces and Personnel Subcommittee. 103rd Congress. 1st Session. National Defense Authorization Act. FY1994. H.R. 2401 and Oversight of Previously Authorized Programs. H.A.S.C. Hearings. No. 103-13. 27 & 28 April, and 10, 11, & 13 May 1993. 505. Cited in Congressional Research Service Brief. Military Medical Care Services. Library of Congress. October 1994.

⁵² Best, Richard A. Military Medical Care Services: Questions and Answers. Foreign Affairs and National Defense Division, Congressional Research Service. Library of Congress. Washington, DC. October 1994. 3.

requiring long-term care than the 733 Study did. Differences also exist in estimates of how many physicians are needed during peacetime to ensure wartime readiness, including the number of physicians needed for rotation of overseas medical personnel, and staffing overseas military hospitals.⁵³ Current Defense Planning Guidance envisions conflicts involving smaller forces and fewer casualties than during the Cold War. As a result, the 733 Study estimated that the armed forces need between 4,930 and 6,264 physicians on active duty to meet wartime requirements, or 40 percent to 50 percent of the 1999 physician manning projection.⁵⁴ The language directed DoD to evaluate alternatives to the current system for providing health care to military beneficiaries.⁵⁵ Several RAND studies revealed that a comprehensive health benefit is seen as essential support for active duty families, who must move frequently and cope with the absence of their active duty members. Military retirees view their health care benefits as an important part of the compensation they were promised. However, many military beneficiaries do have private employer health coverage. If DoD improves the benefit it provides, more beneficiaries can be expected to shift their health care from employer plans to the DoD system. The declining DoD budget could not easily accommodate an increase in health care costs if beneficiaries make this shift. Thus, as the national health care system is reformed, DoD has been looking for ways to meet obligations to beneficiaries that do not lead to excessive cost growth.⁵⁶

Under the sponsorship of the Assistant Secretary of Defense for Health Affairs, RAND's National Defense Research Institute published their evaluation of the CRI in 1994. The study found in the years prior to CRI, CHAMPUS and the MTFs were poorly coordinated. At the same time, beneficiaries were trying to use both systems, often switching back and forth. They would go to the MTF when they could because it was free, but more often would turn to CHAMPUS because they had difficulty in getting appointments at the MTF, which were limited by armed service personnel and budget constraints. Partly as a result, CHAMPUS had grown significantly--while MTF usage actually declined. Thus, DoD had medical care resources that were underutilized by beneficiaries who were dissatisfied with access to and continuity of care. Furthermore, DoD estimated that MTF care cost significantly less than that of CHAMPUS. Since roughly two-thirds of CHAMPUS beneficiaries' health care demand was still being met by the MTFs, inefficiency in using the MTFs could have offset small gains on the civilian side from CRI. As a result, CRI incorporated features intended to increase MTF utilization by more closely linking the civilian and military systems.⁵⁷

A military managed-care program like CRI was extraordinarily complex because it had to coordinate the military and civilian health care systems and accommodate a mobile beneficiary population. It required coordination among civilian and military providers, managed-care companies, fiscal intermediaries, beneficiaries, nonclinical military staff, and federal agencies.

⁵³ Defense Health Care: Issues and Challenges Confronting Military Medicine. GAO/HEHS-95-104. Washington, DC. GPO. March 1995. 27.

⁵⁴ Slackman, Joel. Study of The Military Medical Care System. Pentagon Position Paper. Washington, DC. May 1994.

⁵⁵ Hosek 9.

⁵⁶ Hosek 9.

⁵⁷ Anderson 35.

Early in the CRI demonstration, the contractors believed that inadequate support from DoD and the MTFs hindered their implementation process. Conversely, some MTFs viewed CRI as a purely commercial venture and felt that the military was not being credited for its own efforts to improve beneficiary care.⁵⁸

Beneficiary education was another aspect examined by RAND. Their study emphasized that terminology used to explain programs must be kept as simple as possible. In CRI, misunderstanding resulted from the similarity of names being used (e.g., Prime) to names of other military medical programs (e.g., PRIMUS). The study recommended that various methods should be used to inform beneficiaries about changes to an existing program. Procedures for reducing beneficiary inconvenience and confusion when benefits and procedures change should also be explored. Impressing beneficiaries with the need to keep their eligibility and information about location changes current is also an ongoing task. Unless this is done, benefits could be denied to an enrollee leaving a catchment area with a unique managed-care program.⁵⁹

A primary goal of managed care is cost avoidance. Individuals responsible for managed care development should recognize that military clinicians and administrators have not previously had an incentive to reduce costs. Their priorities are access to high-quality medical care for military beneficiaries and the maintenance of medical training programs. Proponents of managed care hold that it enhances quality and access and can provide a better mix of patients for medical training, but this is not immediately clear to the MTFs' medical staffs. Early attention must be given to convincing them that cost avoidance does not mean low-quality medicine, reduced access to medical care, or degraded training.⁶⁰

The lessons learned from the CAM and CRI led the Army to create its Gateway to Care program in September 1991. It was intended to give local commanders more power to bring families and retirees back into military facilities for treatment. It also created local networks of civilian physicians to meet goals to deliver effective health care without relying on standard contracts covering large sections of the country. For the beneficiary, care was to be continuous with little out-of-pocket expense. Where the Army saved money, local commanders could choose to invest the savings in projects aimed at improving local health care operations.⁶¹ In April 1992, eleven original Gateway to Care sites had opened and by October 1992, all Health Services Command facilities had submitted business plans for their areas.⁶² The success of Gateway to Care was evident by the reduction in the rate of growth of CHAMPUS by 7% for fiscal years 1993 to 1995.⁶³ Gateway to Care has served as the Army's transition plan to the new DoD TRICARE Program: a triple-option, regional contract-based, managed health care program.

⁵⁸ Anderson 59.

⁵⁹ Anderson 60.

⁶⁰ Anderson 60.

⁶¹ Grady, et al. 3.

⁶² Harben, J. "Health Services Built Distinguished Two Decades of Record Service." *The Mercury*. Army Medical Department Publication. Cited by Captain Patrick C. Barrett. "The Political Threat to TRICARE." U.S. Army Medical Department Journal. Fort Sam Houston, TX. May-June 1996. 5.

⁶³ Dohanos, D. "Experience Guides Managed Care Policies." *The Mercury*. December 1995. Vol 23. No. 3:12. Cited by CPT Patrick C. Barrett. "The Political Threat to TRICARE." U.S. Army Medical Department Journal. Fort Sam Houston, TX. May-June 1996. 5.

Managing the military health care system in an efficient manner is difficult. Four organizational officials participate in its management: the Assistant Secretary of Defense for Health Affairs and the Surgeons General of the Army, Navy, and Air Force.

New approaches to military health care delivery require that service commands above the MTF be aware of the complexities of managed care and its resource requirements. Careful planning is needed to avoid unnecessarily disrupting the balance of a catchment area's military and civilian provider network. Base closure and consolidation also create a substantial need for organizational cooperation, planning, and communication to sustain managed care.

The U.S. Government Accounting Office and others have reported on concerns about the ability of DoD to meet its wartime mission, most recently following the Persian Gulf War. These reports described problems such as inadequate training, missing equipment, and large numbers of nondeployable personnel presenting serious threats to the Department's ability to provide adequate medical support to deployed forces. The changing world environment--which generates different demands for care with a smaller force--poses continuing challenges to medical readiness.⁶⁴

The CHAMPUS Reform Initiative improved access for active duty family members and many retirees and their families; however, its cost to the government was running about 19 percent higher than traditional CHAMPUS. In part, the reason for the higher costs to the government came through the surfacing of the "ghost population" of beneficiaries. Many beneficiaries had stopped using the military health care system because of problems of access. The Department of Defense discovered that most of these "ghost" beneficiaries left more costly health care plans offered by their employers to take advantage of the savings to individuals and families under the CRI.

When the DoD proposed expanding the reform initiative into other regions of the country, Congress said no because the cost to the government was rising faster in that program than in any other CHAMPUS program during the early 1990s. What Congress required in the Defense Authorization Act of Fiscal Year 1994 (P.L. 103-160), directed DoD to prescribe and implement, to the maximum extent practical, a nationwide managed health care benefit program modeled on Health Maintenance Organization (HMO) plans. Congress specifically required this new program could not incur costs greater than DoD would incur in the program's absence and that beneficiaries enrolling in the managed care program would have reduced out-of-pocket costs. Drawing from its experience with the demonstration projects, DoD designed TRICARE as its managed health care program.⁶⁵

The array of programs described heretofore is not only confusing but also borders on being unmanageable. In addition, these programs have resulted in unequal benefits for beneficiaries across the country. Congress has recognized this problem and has mandated DoD to pick one approach to managed care and implement it throughout the nation.

⁶⁴ Issues and Challenges Confronting Military Medicine 2.

⁶⁵ Defense Health Care: New Managed Care Plan Progressing, But Cost and Performance Issues Remain. GAO/HEHS-96-128. GPO. Washington, DC. June 1996. 3.

Transition to TRISERVICE CARE--TRICARE

Vision Statement

TRICARE is designed to ensure the most *effective* execution of the military health care mission, recognizing the need to ensure access to secure *quality* health care benefits, *control* costs, and respond to *changing* national military and health care priorities.

The TRICARE Program

The old system of the military's medical services is no longer an option for reasons beyond the control of DoD. The end of the Cold War was a boon to all humanity, but resulted in huge cuts in our forces, including medical services. The number of beneficiaries is not shrinking as fast, so overall there is less space available in military hospitals. DoD medical leaders believe they have found a better way-- one that efficiently knits military and civilian resources into a seamless system to maintain or improve quality, increase access, and control costs for beneficiaries and taxpayers. TRICARE is that better way. TRICARE improves our military medical system by efficiently using remaining military medical assets and supplementing them with civilian care. Once the transformation to TRICARE is complete, defense officials predict the military health care system will be easier to understand. While this may be true on one hand, it will still seem complicated and confusing to many simply because of the changes which are taking place and the available options which require personal decision making.

The review of numerous studies and attempted health care reforms described in this report provides an appreciation for the monumental tasks addressed in order to put military health care on the threshold of an entirely new and better way of doing business for the years ahead. With fewer military doctors and hospitals, and rising costs to both the government and beneficiaries, military health care had to change.⁶⁶ In response to the mandate for change, TRICARE was designed to provide enhanced access to health care for all beneficiaries within defined budget limitations. The changes that are taking place are meant to improve care for beneficiaries at military hospitals, clinics, and pharmacies; save money; and shift the focus from treatment to prevention. The emphasis will be on wellness, prevention of disease or illness, and personal responsibility for healthy living.⁶⁷ DoD's transition to managed care has not been easy and important lessons have been learned concerning features that need to be in place as managed care efforts continue.

To implement the TRICARE program in the most effective way possible, DoD is transitioning from standard fee-for-service financing of care purchased from civilian providers under CHAMPUS to large TRICARE Support Contracts for each of the twelve Health Service Regions. These TRICARE Support contracts, procured centrally by the Office of CHAMPUS, will assist Lead Agents and MTFs in meeting their responsibilities to improve access to quality health care while containing costs. They are fixed-price, at-risk contracts intended to provide substantial incentives for the civilian managed care contractors to develop innovative programs

⁶⁶ "Change is not made without inconvenience, even when it is from worse to better." Author unknown.

⁶⁷ Grady, et al. 8.

and linkages with the MTFs. In some cases, a single contract will support multiple regions.⁶⁸

In April 1994 testimony to the House Armed Services Committee, senior DoD health care officials summarized the "733 Study" and announced the establishment of a DoD-wide, joint-service managed-care system called TRICARE. Under TRICARE, there will be 12 DoD Health Care Regions (See Appendix B: TRICARE Health Care Regions) managed by the military in partnership with civilian contractors. For each Region, a military Lead Agent will be responsible for over-seeing the program. Lead Agents are the Regional commanders of the services' hospitals within a Region, however, each hospital has a separate commander. Each Region will have a "capitated budget" based on the total number of beneficiaries in the Region. Although TRICARE is intended to streamline health care delivery, assure high quality care, and reduce duplication of effort, it may not limit the rise in health care costs. Any significant improvement in the quality of health care services or reduction in beneficiaries' out-of-pocket expenses may have the effect of drawing in additional beneficiaries into the MHSS who are currently using non-DoD services. According to Congressional Budget Office estimates, there are over two million of the "ghost beneficiaries" who would have a major effect on DoD health care costs.⁶⁹

The medical portion of the President's Fiscal Year 1996 Defense Budget, \$15.2 billion, will afford DoD the resources to ensure that health care continues to be a successful contribution to quality of life in the military. Of the total medical budget, almost \$9.6 billion will be used for the Defense Health Program to provide support for worldwide medical and dental services to the active forces and other eligible beneficiaries, veterinary services, medical command headquarters, specialized services for the training of medical personnel, and occupational and industrial health care. Health care services will be provided in 124 military hospitals and 504 clinics for a beneficiary population numbering 8.3 million.

Included in the \$9.6 billion FY 96 medical budget is \$3.5 billion in costs associated with the CHAMPUS and TRICARE Managed Care Support Contracts (MCSC). In 1993, DoD began a transition to the managed care concept of operation by adding several new components to its health care program. TRICARE integrates CHAMPUS with the MTFs on a Regional basis. TRICARE realigns the MHSS into 12 DoD joint-service health care Regions. The MCSC initiative, a significant component of TRICARE, will transition the purchase of health care and support services from civilian sources under the basic CHAMPUS program (fee-for-service) to fixed-price at-risk contracts. The FY 97 Defense Health Program funds the costs of seven MCS contracts (covering all 12 Regions) that are being negotiated and procured by the Office of CHAMPUS, within the OASD(HA), not by the Lead Agents of each Region.⁷⁰

Under TRICARE, seven managed care support contracts will be awarded for the 12

⁶⁸ Joseph, Stephen C., M.D., M.P.H. "Policy Guidelines for Implementing Managed Care Reforms in The Military Health Services System." Health Affairs Policy 96-025. OASD(HA). Washington, DC. January 1996. America Online. July 1996. 14. Webmaster@HA.OSD.MIL.

⁶⁹ Best 8.

⁷⁰ Joseph, Stephen C., M.D., M.P.H. "DoD Medical Program, FY97." Assistant Secretary of Defense for Health Affairs. Statement to The Subcommittee on National Security and Committee on Appropriations. U.S. House of Representatives. 104th Congress. 2nd Session. 24 April 1996. Washington, DC. America Online. 10 June 1996.

TRICARE Regions with some of the contracts covering more than one Region.⁷¹ Each support contract will be awarded to a single private-sector health care company to supplement the care available in the military medical facilities in the Region and to provide administrative support to the Lead Agent and medical facility commanders and staff. The contracts are for a 5-year period and DoD estimates that they have a combined value of about \$17 billion. Contractors will not manage the overall health care program. TRICARE contracts have been and are being rigorously drafted to ensure military oversight and will be resolicited after the 5-year period. DoD plans to have all seven contracts awarded by mid-1997 with TRICARE fully implemented in all Regions by early 1998.⁷² Of the two currently pending contracts, one will cover Regions 2 and 5 and the last to be awarded will cover Region 1.

The Desert States TRICARE Support Office, Region VII, located at the William Beaumont Army Medical Center, El Paso, Texas, announced on 27 June 1996 the award of a \$2.32 billion contract to the TriWest Health Care Alliance of Phoenix, Arizona. This contract, with provisions for the adjustment of health care prices, is for Managed Care Support Services in Arizona, Colorado, Idaho (except for six counties in northern Idaho), Iowa, Kansas, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, Southwest Texas (El Paso area), Utah, and Wyoming. This contract will cover 740,000 beneficiaries in the area listed, including more than 400,000 within the Region VII area of responsibility. The five-year contract provides for a seven-month start-up period plus one-year option periods. Proposals were solicited from 278 offers and four proposals were received. Managed-care in the El Paso/Fort Bliss area is anticipated to begin operation by 1 April 1997. Region VII, also known as the Desert States TRICARE, is headed by a Lead Agent, United States Army Brigadier General Nancy Adams, and includes Arizona, New Mexico, Nevada and Southwest Texas.⁷³ General Adams has the unique distinction of being dual hatted as the Lead Agent of Region VII and commander of the Southwest Region Medical Command. Currently, consideration is being given to combining the Lead Agents of Region VII and Region VIII into one agent located at Fort Carson, Colorado.

Capitated Method to Allocate Funds

TRICARE, like other managed care programs, uses a capitation method to allocate health care funds. Capitation is a strategy/method for containing the cost of health care by allocating resources based on a fixed amount per beneficiary in the population rather than fee-for-service. In the past, DoD medical facilities were funded on the basis of historical workloads, which rewarded high resource utilization with increased budgets. However, as part of its transition to TRICARE, in 1994 DoD adopted a modified capitation method, with the ASD(HA) allocating some resources to the services' medical departments on a per capita basis. The TRICARE program fundamentally shifts the orientation of the managed health care portion of the MHSS away from a focus on

⁷¹ Single contracts will cover Region 1; Regions 2 & 5; Regions 3 & 4; Region 6; Regions 7 & 8; Region 11; and Regions 9, 10, & 12.

⁷² Issues and Challenges Confronting Military Medicine 40.

⁷³ Joy, Ron. "Billion Dollar Region VII TRICARE Contract Awarded." William Beaumont Army Medical Center Public Affairs Office. The Monitor. El Paso, TX. 3 July 1996.

performance of facilities to a focus on managing the health care needs of people. This change in DoD health care resource allocation removes fiscal incentives for admissions over outpatient treatment.

Medical functions that are unique to the military and related to military readiness and the size of the military force are capitated on the basis of the active duty population. Funding for operating and maintaining the direct care system and CHAMPUS will be capitated, using a fixed-dollar amount for each beneficiary DoD estimates to be using the MHSS. These funds are allocated from the central Defense Health Program that was established to improve overall management of the military health services program.⁷⁴ The services' medical departments pass the direct care funds on to the individual medical facilities using their own service-unique capitation methodologies, making each medical facility commander responsible for providing health services to a defined population for a fixed-dollar amount per beneficiary. This approach is intended to remove incentives for inappropriate or prolonged hospital stays, unnecessary services provided, or otherwise provide more costly care than is medically appropriate. CHAMPUS funds are not provided to the medical facilities but are pooled together at the service level to fund the TRICARE managed care support contracts in each Region.⁷⁵ Lead Agents are responsible for and have the authority to oversee CHAMPUS dollars for their Regions. Each hospital within a Region is funded directly for direct care and military personnel; however, CHAMPUS funds are managed on a Regional basis. Although the capitated budget of the MTF includes its CHAMPUS target, these targets are rolled up to the Regional level for Lead Agent oversight. Thus, a balance will have to be achieved between direct care and CHAMPUS operations.⁷⁶

Because a capitated allocation system makes the MTF commander responsible for providing all health services, there are built-in incentives for care to be provided in the most cost-effective setting--the use of preventive services, the efficient delivery of each episode of care, and the careful monitoring of the volume of provided services. And, because the MHSS sets the capitation amount prospectively, the health care provider cannot influence the funding received for beneficiaries' care within the period of the allocation.⁷⁷

The federal agency that administers CHAMPUS/TRICARE worldwide is the Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS). Its parent office is the Office of the Assistant Secretary of Defense for Health Affairs. The ASD(HA) works for the Secretary of Defense, who works for the President. OCHAMPUS, located in Aurora, Colorado, maintains a Benefit Services Branch specifically to address beneficiaries' concerns and questions.

⁷⁴ Joseph, "Policy Guidelines..." 9.

⁷⁵ Issues and Challenges Confronting Military Medicine 42.

⁷⁶ Joseph, "Policy Guidelines..." 11.

⁷⁷ Joseph, "Policy Guidelines..." 9.

Utilization/Quality Management Under TRICARE

Quality assurance and utilization management programs will monitor appropriate utilization of medically necessary services to ensure that budgetary controls do not erode the provision of needed care. While utilization management and quality management are not synonymous, their goals and mechanisms frequently overlap. Ideally, utilization management ensures eligible beneficiaries receive care necessary and appropriate to their clinical needs. Quality management seeks to continuously improve the quality of health care delivered to an entire beneficiary population, thereby improving the health status of the population as a whole. The term "quality management", as opposed to "quality assurance", carries the implication that continuous quality improvement is incorporated into the program. Cost containment initiatives must not emphasize lower costs at the expense of compromising the medical needs of the patient.⁷⁸

The decision to organize the MHSS along Regional lines provided an opportunity to initiate a uniform set of guidelines regarding utilization management and quality monitoring across the entire system. To implement such a plan, it was necessary to recognize the needs and functions peculiar to utilization management and quality assurance. These include the patient, the Lead Agent, the MTF, the TRICARE Managed Care Support Contractor (MCSC), and the network and non-network providers, the National Quality Monitoring Contractor, the services, and Health Affairs. The TRICARE MCSC may be requested by the MTF to perform utilization management functions, such as preauthorization, concurrent and retrospective reviews, case management, discharge planning, and waiver considerations, for all types of care in all settings. The quality management program will consist of elements that collectively give reasonable assurance that care is consistent with the patients' needs, delivered by providers acting within the scope of their training and credentialing, and of continually improving quality. Activities will include retrospective review of care by panels of military and civilian experts. Reviews will have a primary goal of improving health care through the discovery of the best clinical practice, with the identification of problem providers being secondary, but nonetheless, a very important goal.⁷⁹

DoD, Lead Agents, and military medical facility officials view utilization management as a key to containing costs and ensuring health care quality and access. The TRICARE program fundamentally shifts the orientation of the managed health care portion of the MHSS away from a focus on performance of facilities to a focus on managing the health care needs of people. Each Lead Agent must develop a written utilization management plan for care provided throughout the Region, whether in the direct care system or through the MCSC. Lead Agents may choose to contract for utilization management services for the direct care system, or the military medical facility may retain those functions. Regardless of who performs the functions, the activities must be carried out following uniform DoD utilization management policy guidance.⁸⁰

Some civilian insurance companies use the term "managed care" to refer to their systems for reviewing and approving--or disapproving--doctors' recommendations. This approach has

⁷⁸ Joseph, "Policy Guidelines..." 17.

⁷⁹ Joseph, "Policy Guidelines..." 18.

⁸⁰ Issues and Challenges Confronting Military Medicine 43.

received bad publicity because of doctors' and patients' objections to having medical decisions second-guessed by non-medical people. However, military "managed care" is different. An essential element to TRICARE is "utilization management" which employs the team approach, so essential to quality care for the patient. Under this concept, difficult or complicated cases receive an independent review by knowledgeable health care professionals. This built-in second opinion should be a big reassurance to patients and their families.

Lead Agent Responsibilities

The reorganization of medical facilities into joint-Service Regions and establishment of the new Lead Agent structure represents a significant change to the administrative structure of the military health system. DoD policy for TRICARE states that the success of the program relies, to a great extent, on interservice cooperation and the administrative skills of the Lead Agents. Officials from Lead Agent offices and military hospitals are concerned about the degree of control or authority the Lead Agents and medical facilities will have and the extent to which they can effectively manage the delivery of care within the Region.

Issues related to Lead Agent control and authority are inherently complex because TRICARE calls for the Lead Agent to coordinate all care provided within the Region (including care provided by the contractor). However, the services retain command and control over their military facilities and personnel, with each facility accountable to its parent service. Therefore, the Lead Agent does not control the funds that flow from the services to their respective facilities or the CHAMPUS funds, which are controlled by DoD and the contractor.

The Lead Agents must also overcome the effects of interservice rivalries that have historically hampered efforts to establish more efficient health care delivery systems. For TRICARE to be successful, Lead Agents must foster teamwork that crosses traditional service boundaries. This is especially important since Lead Agents do not command any hospital within their respective Region. For example, the Air Force Lead Agent in one Region will oversee and manage the delivery of health care by 19 Army, Navy, and Air force military hospitals and clinics and the civilian contractor. The Army serves as Lead Agent in five Regions, the Navy in two Regions, and the Air Force in four Regions. The Lead Agent for the National Capital Region will alternate annually among the three services. Although communication among the services appears to have improved, the Lead Agents' challenge will be to convince hospital officials and headquarters commands of the other services to participate in initiatives to improve health care delivery in the entire region. Lead Agents do not exercise command authority or make decisions about individual hospital operations, but are encouraged to share their experiences and successes among themselves and with the MHSS leadership so that, utilizing the tenets of Total Quality Leadership, TRICARE and the entire MHSS can be enhanced. The extent of interservice cooperation and the administrative skills Lead Agents can offer are going to be critical determinants of the success of TRICARE.⁸¹

The composition of each Regional office is determined by the Lead Agent in coordination

⁸¹ Issues and Challenges Confronting Military Medicine 44.

with other MTFs in the Region and includes Tri-Service staffing. When instituting changes necessitated by the transition to Regionally-based health service plans, Lead Agents must seek concurrence by the Military Departments and MTF commanders. In the event of a disagreement, resolution will be sought first at the Regional level by the MTF commanders and the Lead Agent. Unresolved disputes will be elevated by the Lead Agent within ten working days to their parent Service Surgeon General for coordination and resolution with the concerned Military Department. Unresolved disputes at the Surgeon General level will be forwarded for final disposition to the ASD(HA) through the Assistant Service Secretaries for Manpower, Readiness, and Reserve Affairs. The final decision regarding the issue under dispute will be provided within ten working days by the ASD(HA).⁸²

TRICARE Options and Features

TRICARE features a triple-option benefit, offering beneficiaries eligible for CHAMPUS two new options for health care in addition to the CHAMPUS program. The options vary in the choices beneficiaries have in selecting their physicians and the amount beneficiaries are required to contribute toward the cost of their care received from civilian providers. The costs of these options to the beneficiary are shown in Appendix C: TRICARE Triple Option Costs.

TRICARE Standard is CHAMPUS fee-for-service under another name. In this option, individuals pay current CHAMPUS deductibles and cost shares and abide by current CHAMPUS rules. This option provides beneficiaries with the greatest freedom in selecting civilian physicians, but requires the highest beneficiary cost share. The annual deductible--which is the amount individuals must pay before TRICARE pays anything--remains the same as under Standard CHAMPUS. For example, beneficiaries using TRICARE Standard must meet an annual deductible for outpatient care ranging from \$100 for families of active duty personnel at or below the E-4 level to \$300 per family above the E-4 level, retirees, their dependents, and survivors. In addition to the deductible, active duty family members' cost shares or copayments--the portion paid by patients themselves--are 20 percent of the cost of outpatient care and \$25 per inpatient admission or \$9.50 per day, whichever is greater. Retirees, their dependents, and survivors contribute more toward their care, paying 25 percent of outpatient costs and the lesser of \$323 per day of inpatient care or 25 percent of the hospital charges, as well as 25 percent of related professional medical services. Another potential cost under TRICARE Standard is that patients may be responsible for paying the difference between a provider's billed charges and the CHAMPUS allowable rate, known as balanced billing. In addition, beneficiaries may have to file their own claims.

TRICARE Extra is a variant of CHAMPUS. It offers the advantage of an integrated network of health care providers who accept a reduced CHAMPUS payment in return for the business the local military facility refers to them. TRICARE Extra uses contracted civilian providers under the Preferred Provider Network (PPN) program, organized by the contractor. To

⁸² Joseph, "Policy Guidelines..." 6.

join the PPN, doctors and other providers agree to charge lower fees for military beneficiaries and handle all claims filing. To use TRICARE Extra and to benefit from the lower fees and claims filing, a beneficiary needs only to make an appointment with a network member. There is no enrollment or registration requirement, nor is there any commitment to use the PPN in the future. Seeing PPN members saves beneficiaries money because in addition to doctors charging lower fees, TRICARE rules set the patient's share of the cost.

TRICARE Extra, is a preferred provider option, through which beneficiaries receive a 5 percent discount on the Standard option cost of care when they choose a medical provider from the contractors' PPN network. The outpatient deductibles are the same as the Standard option, but active duty dependents pay a 15 percent copayment, with other beneficiaries paying a 20 percent copayment. Active duty dependents pay the same amount for inpatient care as under the Standard option, but retirees and others have a reduced cost share under EXTRA, paying the lesser of \$250 per day or 25 percent of the hospital charges, as well as 20 percent of related professional medical services. Beneficiaries are not required to enroll in the Extra option or exclusively use network providers, but may use network providers on a case-by-case basis.

TRICARE Extra could be just what is needed in areas of the country where there is a significant number of beneficiaries but no military medical facilities. Contractors may create stand-alone PPNs in those communities.

TRICARE Prime is the managed care or Health Maintenance Organization (HMO) option and represents the greatest change in MHSS health care delivery. The Prime option offers the scope of coverage available today under Standard CHAMPUS, plus additional preventive and primary care services. It offers the most comprehensive coverage at the lowest cost to the beneficiary, and as such, most beneficiaries are expected to select this option. TRICARE Prime provides health care primarily at the MTF, augmented by the contractor's PPN. Beneficiaries are assigned to Primary Care Managers (PCM) who may be an individual provider, such as a family practice, internal medicine or general practitioner; or a clinic or panel of practitioners. Where possible, those PCMs will be part of the military medical facility. However, some beneficiaries may be assigned PPN members as their PCM. Either way, the PCM assist with access to necessary, quality health care services; making timely appointments and speciality appointments at reduced overall costs. Beneficiaries must enroll for TRICARE Prime and are committed to it for one year after which they may choose another option. Beneficiaries must agree to follow the plan for obtaining health care or they may be liable for large deductibles and up to fifty percent of the cost of services they obtain from outside the plan on their own.

Beneficiaries selecting this option must enroll annually in the program, agreeing to go through an assigned military or civilian primary care physician for all care. Low enrollment fees and copayment features provide financial incentives for beneficiaries to select this option, the most highly managed of the three options. For example, Prime enrollees are not required to meet an annual deductible, but retirees, their dependents, and survivors enrolled in the option must pay an annual enrollment fee of \$230 for an individual and \$460 for a family which can be paid quarterly. Cost-sharing requirements for care provided by civilian providers range from \$6 a visit for active

duty dependents of lower rank military personnel (E-4 and below) to \$12 a visit for dependents of higher rank personnel, retirees, their dependents, and survivors. Cost-sharing requirements for inpatient care are significantly lower than for the other options. Regardless of their beneficiary category, all enrollees pay the greater of \$25 per admission or \$11 per day.

Active duty personnel are automatically part of TRICARE Prime with no fees. There will be no significant difference in the way they receive health care. They will be assigned to military health care providers at or near their duty stations. If a service member requires medical services not offered at their MTF, they will be sent to another MTF or receive civilian care at government expense. From the service members' perspective, this is the way it has always been for traditional supplemental care and they will see no change. Active duty families who are assigned to a civilian PCM under TRICARE Prime or who use TRICARE Extra will save money compared to what they would spend if they used Standard CHAMPUS. There are no enrollment fees for active duty families.

The PCM is the key to improving access to all health care services within TRICARE Prime. Enrolled beneficiaries have one place to go for all their primary care needs and for assistance in getting specialty care. The PCM focuses on the whole person, providing a personal, one-on-one link to tie together all aspects of an individual's health care. The PCM also provides preventive services and patient education, helping patients take a more active role in their own care and a greater responsibility for their own health. Beneficiaries will be provided a choice in selection of their PCMs to the maximum extent feasible. However, MTF commanders have the final authority to determine the most appropriate selection of PCMs for the beneficiary. MTFs will ensure beneficiaries are provided full and fair disclosure, prior to their enrollment, of any and all restrictions on freedom of choice that may be applicable to them. This includes the requirement for MTF enrollees who are referred to a civilian provider to pay all appropriate Prime cost-shares.

The TRICARE Service Center (TSC) is the hub for all beneficiary support services. It works closely with the PCMs in helping patients get care from the civilian network. The TSC also conducts enrollment and provides general beneficiary information and assistance. Health Care Finders (HCFs), who are physicians, nurses, or physician assistants are available 24-hours per day, seven days a week, via a toll-free phone number. They assist both enrollees and non-enrollees, including Medicare eligible beneficiaries to get appointments with PPN providers. HCFs also provide information and assistance, and approve certain referrals.

TRICARE Prime enrollees must go through their HCF for all medical care except visits to their own PCM and bonafide emergency care. Anyone bypassing the system will pay a much higher than normal price for his or her care. This rule applies whether the patient is in their local area or traveling elsewhere. To ensure this does not create a barrier to access, HCFs are always available through toll-free numbers.

Challenges Still Facing TRICARE

Medicare eligible beneficiaries, those over age 65, remain entitled to space-available care in MTFs. If space is not available, the TSC will help find local providers who accept Medicare patients and Medicare assignment for payment in full. The standard Medicare deductible and copayment still apply and there is no charge for this referral service. At the present time, Medicare eligible beneficiaries cannot enroll in TRICARE because of current laws that prohibit the transfer of Medicare funds to the TRICARE system. When Medicare beneficiaries have to get civilian health care, their Medicare benefits will pay the standard Medicare cost share.

For the past several years, DoD has advocated changing the law to implement Medicare subvention--financial reimbursement to the military for elderly patients. DoD originally proposed to demonstrate Medicare subvention in two TRICARE Regions and Alaska.⁸³ Congressional legislation was proposed before the 1996 Congress to let Medicare reimburse MTFs for medical services provided to Medicare beneficiaries. Had it been approved by Congress, beneficiaries 65 and older could have enrolled in TRICARE Prime, and the new source of money would have expanded availability of MTF care for them. Proponents argued that a subvention test would show that it is more efficient than turning the elderly away from military hospitals to rely on Medicare and civilian health care providers. Also, without subvention, space-available military care for the elderly will all but disappear within several years as military facilities close and downsize and TRICARE expands across the country.⁸⁴ Compounding the Medicare problem is a projection that it will go broke between 2001 and 2004 and possibly sooner under the weight of today's aging population. Additionally, the number of Medicare eligible will double between 2010 and 2030.⁸⁵

Care for military retirees and their dependents and survivors is an important issue for both beneficiaries and DoD. Concerns about their access to military health care services, as well as Medicare-eligible beneficiaries' ineligibility for CHAMPUS, existed before TRICARE and would still exist regardless of whether TRICARE had been instituted. At issue is whether, and/or how, DoD can help provide care for retirees without impeding access for other beneficiaries or greatly increasing costs. While many beneficiaries state they were told they would have free medical and dental care for life based on former military service, laws have not provided nonactive duty beneficiaries an unqualified commitment for unlimited medical care without charge. What has traditionally been misunderstood by former service members is that while they are "eligible" for care in MTFs, they are not "entitled" to that care except as resources permit. Title 10, United States Code, states that retired personnel "...may, upon request, be given medical and dental care in any facility of any uniformed service, subject to the availability of space and facilities and the capabilities of the medical and dental staff." Unfortunately, those capabilities can no longer fully meet the demands for health care.

⁸³ Gilbert, Douglas J. "DoD Moves Closer to Over 65 Health Care." The Monitor. El Paso, TX. 20 June 1996.

⁸⁴ Philpott, Tom. "Agency Will Miss Medical Report Deadline." El Paso Times. El Paso, TX. 22 August 1996. 4 West.

⁸⁵ Raspberry, William. "Health Care Will Ultimately Be Our Responsibility." Quoted interview with Leonard D. Schaeffer, Chairman and CEO of WellPoint Health Networks and Blue Cross of California. El Paso Times. El Paso, TX. 12 June 1996.

Currently, military retirees, survivors, and their dependents make up over half of all those eligible for care and almost a third of those, about 1.2 million people, are age 65 and over. This Medicare-eligible population is expected to grow by 25 percent through the year 2002, while the number of the rest of the military population is expected to decline. DoD has traditionally treated many retired beneficiaries in military hospitals on a space-available basis. DoD officials contend that some care of this population is important for training and practice needed to maintain wartime readiness of their physicians because it adds to the physicians' range of experiences. However, DoD health care eligibility legislation and funding considerations in TRICARE constrain the ability of DoD to include Medicare-eligible beneficiaries in the TRICARE program.

Several potential solutions have been offered by DoD, beneficiary groups, and the Congress, including: (1) reimbursement to DoD by the Health Care Financing Administration for care provided to Medicare-eligible beneficiaries (subvention); (2) extending CHAMPUS coverage to beneficiaries aged 65 and over as a second payer to Medicare, and; (3) offering coverage under the Federal Employees Health Benefits Program. The cost and effectiveness of these and other proposals remain uncertain but are obviously very important.⁸⁶

Frustrated that Congress would not authorize a test of Medicare subvention this year, DoD has decided to launch one without benefit of legislation, starting early in 1997. Elderly retirees, dependents and survivors living near selected military medical centers will be invited as early as May, 1997, to enroll for a year in TRICARE Prime. Enrollment of Medicare eligibles 65 and older will be limited to less than half the number of elderly still able to access the system on a space-available basis. Enrollment will be on a first-come, first-served basis, but won't begin until the program is officially announced in each area.

The projected test, referred to as TRICARE Senior, has been cleared by the White House's Office of Management and Budget. It is also important to note that enrolled Medicare eligibles will face higher out-of-pocket costs than other TRICARE Prime participants. Only persons with Medicare Part B coverage will be allowed to enroll and they will not have priority access to the usual TRICARE annual enrollment. Like all enrollees, Medicare eligibles would agree to seek all care through a PCM and will have priority access to the MTFs, not just space available.

When the care managers can't find space in a MTF and refer patients to civilian care providers, Medicare eligibles will have a co-payment to make. The care provider will bill Medicare at fee-for-service rates and patients who lack supplemental health insurance will pay all costs not covered by Medicare.

The main purpose of the test is to gather data. For the first time, officials will track and compare the military cost of treating Medicare eligibles with costs reported by Medicare for similar cases handled by private sector providers in the same area. Additionally, defense officials hope by simulating the demonstration so far rejected by Congress, they can prove to the guardians of the Medicare trust fund that a full-scale subvention program actually would save Medicare money. Subvention not only could reverse the exodus from military facilities but would actually

⁸⁶ Backhus, Stephen P. "TRICARE Progressing But Some Cost and Performance Issues Remain." Statement before Subcommittee on Military Personnel. Committee on National Security. House of Representatives. 7 March 1996. GAO/T-HEHS-96-100. Washington, DC. March 1996. 6-7.

save Medicare dollars by providing care more inexpensively than charged by Medicare providers in the private sector.⁸⁷

In order for TRICARE to succeed, the MHSS must extensively promote quality organizational cultural and philosophical changes where health professionals feel free to contribute their ideas, where involvement in problem solving and decision making are the norm. Health professionals must be encouraged to constantly strive to find better, more effective ways to meet their myriad of responsibilities. The underlying values needed to make Total Quality Management effective must be internalized by the services' leadership on down to the health professionals responsible for the actual delivery of an improved military health care system. Otherwise, the result will be abandonment of the improvement effort and of TQM.⁸⁸ Encouraging improvements require a paradigm shift. Effort to simply mandate TQM is a sure way to failure. Dr. W. Edward Deming, a recognized expert in the area of TQM, sees the improvement of quality as "...the key to reducing costs, improving productivity...and fostering organizational growth."⁸⁹

Conclusion

The DoD Health Services System has been through many changes since the Continental Army took its first casualties. Today, the military medical system includes hundreds of hospitals and outpatient facilities, treating millions of beneficiaries every year. The military and civilian professionals and paraprofessionals who make this system work are deserving of great praise for their dedication to excellence. The 400,000 individuals working in this system have faced, and will continue to face, many challenges as they seek to provide the best possible care in aging facilities with dwindling budgets and constant personnel turnover. In spite of these challenges, or possibly because of them, the MHSS has developed into a system that provides an exemplary level of quality health care. Meanwhile, the defense drawdown will continue to exert pressure on the system to do more with less. It is hoped that our services' commitment to excellence will continue to produce improved quality health care beyond the call of duty.

Military medical care, and American health care in general, are in a state of transition. The lessons that have been learned to date and the concerns raised by various groups of beneficiaries demonstrate that many TRICARE implementation issues remain. Overcoming challenges will require innovation, persistence and, above all, compromise in order to reach consensus among widely differing views held by DoD, MHSS, Congress, and beneficiaries. It is also crucial that expectations for the success of managed care be tempered by realism about the prospects for immediate beneficial results. DoD and the country are dealing with difficult and costly health care problems with many implications for those affected by the health care system. At the same time, Congress is seeking ways to reduce health care costs in federal medical programs as part of the

⁸⁷ Philpott, Tom. "Military Will Test Subvention Without Legislative Help." El Paso Times. El Paso, TX. 27 November 1996. 2 West.

⁸⁸ Sashkin, Marshall and Kenneth J. Kiser. Putting Total Quality Management to Work. San Francisco, CA. Barrett-Koehler Publishers. 1993. 166.

⁸⁹ Walton, Mary. The Deming Management Method. New York. The Putnam Publishing Group. 1986.

effort to reduce the federal deficit. It will take time to work through equitably accommodating those affected, while achieving the goals of controlling cost growth, improving access, and maintaining quality. It is therefore incumbent on all beneficiaries to be aware of the various alternatives being proposed and to realistically assess their impact.

TRICARE is all about managing the transition to and the delivery of total quality health care. It is the military's commitment to producing the best health care system possible and an evolving process which continually strives for ways to make health care better. There will never be a time when the quality of this new way of delivering health care is 100 percent right, but it portends to be better than anything DoD has had in the past.

DoD will continue to evolve TRICARE into the best health care plan--essentially the largest HMO--in the country. In doing so, health professionals must work within the constraints of their budgets while also being as efficient and effective as possible in order to maximize the readiness of military forces. The shift from process oriented workload counting to healthy beneficiaries has begun to enable health care providers to concentrate on developing strategies and methods to encourage healthy lifestyles, emphasize preventive measures, and return sick and injured patients to full health and functionality as efficiently and quickly as possible. Military medicine now has in place the tools necessary to lead and shape the MHSS to meet its twin missions of medical readiness for wartime and peacetime health care, into the next century.

Appendix A: Profile of U.S. Medical Treatment Facilities, Community Hospitals, and Beneficiaries

<u>Region</u>	<u>Lead Agent</u>	<u>States in Region</u>	<u>Beneficiary Population</u>	<u>MTFs</u>
1 Northeast	National Capital (Bethesda, Walter Reed, and Malcolm Grow Medical Centers)	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and Northern Virginia	1,093,918	10
2 Mid-Atlantic	Portsmouth Naval Hospital	North Carolina and Southern Virginia	872,011	7
3 Southeast	Eisenhower Army Medical Center	Georgia, South Carolina, and parts of Florida	1,063,011	12
4 Gulf South	Keesler Air Force Medical Center	Alabama, Mississippi, Tennessee, and parts of Louisiana and Florida	595,024	9
5 Heartland	Wright-Patterson Air Force Medical Center	Illinois, Indiana, Kentucky, Michigan, Ohio, West Virginia, and Wisconsin	653,328	5
6 Southwest	Wilford Hall Air Force Medical Center	Arkansas, Oklahoma, and parts of Louisiana, and Texas	949,778	13
7 Desert States	William Beaumont Army Medical Center	Arizona, Nevada, New Mexico, and parts of Texas	323,056	8
8 North Central	Evans Army Community Hospital	Colorado, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, North Dakota, South Dakota, Utah, Wyoming, and parts of Idaho	732,821	13
9 Southern California	San Diego Naval Hospital	Southern California	710,461	6
10 Golden Gate	David Grant Air Force Medical Center	Northern California	382,590	3
11 Northwest	Madigan Army Medical Center	Oregon, Washington, and part of Idaho	350,439	4
12 Hawaii-Pacific	Tripler Army Medical Center	Hawaii	151,750	1
Total.....			7, 878,187	91

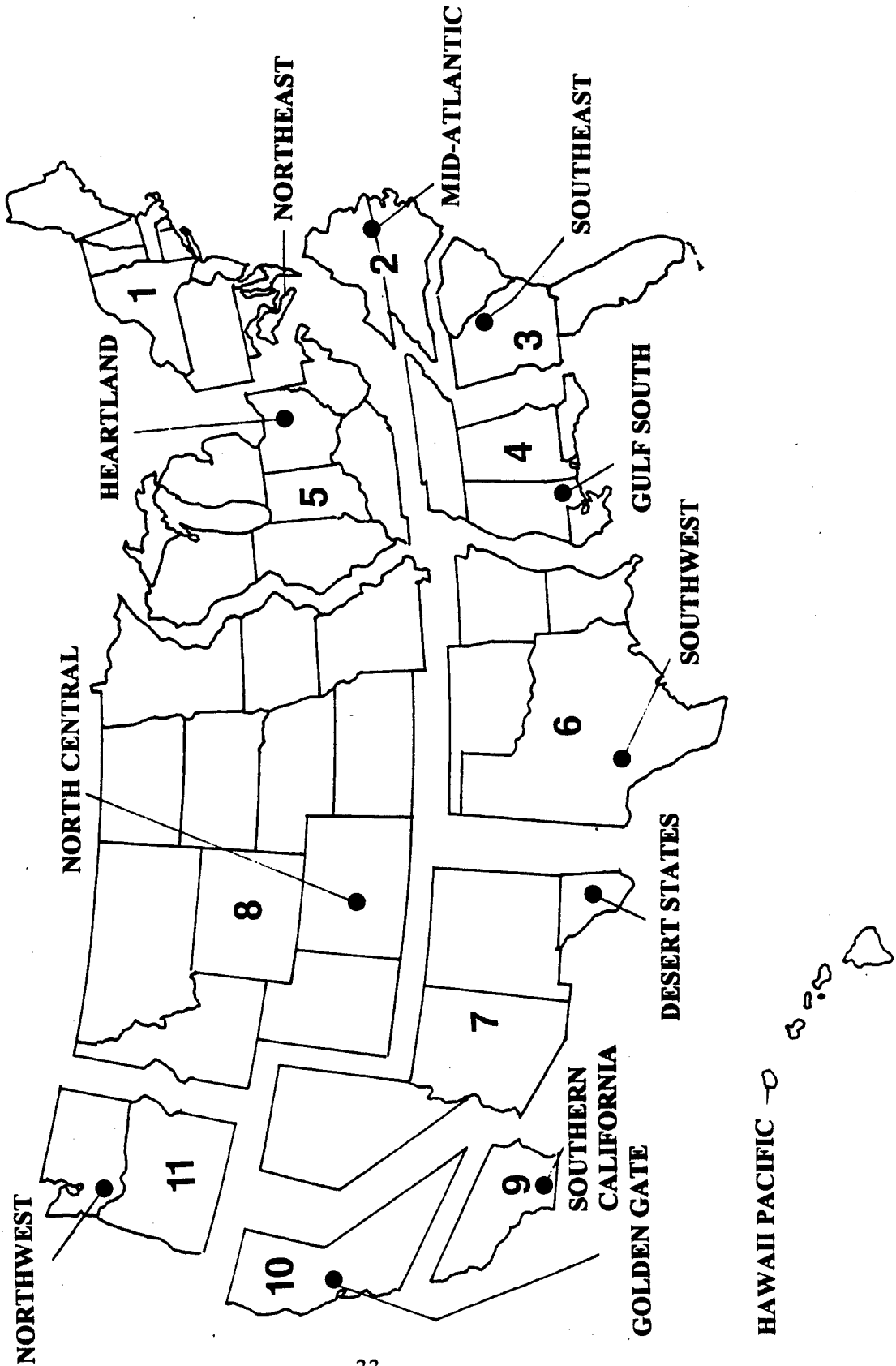
Note: The cumulative total of this appendix does not include the overseas beneficiary population which when added to the CONUS beneficiary total reflected above, equals approximately 8.2 million. MTFs represent the total number of Military Treatment Facilities and community hospitals participating in TRICARE.

Source: General Accounting Office Report. New Managed Care Plan Progressing, But Cost and Performance Issues Remain. GAO/HEHS-96-128. Washington, DC. August 1995.

Appendix B: TRICARE Health Care Regions



TRICARE EUROPE
(Under Development)



Appendix C: TRICARE Triple Option Costs

	TRICARE Prime	TRICARE Extra	TRICARE Standard
Annual Deductibles:			
Families of E-4s and Below	\$0	\$50/\$100	\$50/\$100
Other Active Duty Families	\$0	\$150/\$300	\$150/\$300
Retirees and Others	\$0	\$150/\$300	\$150/\$300
Annual Enrollment Fees:			
Families of E-4s and Below	\$0	\$0	\$0
Other Active Duty Families	\$0	\$0	\$0
Retirees and Others	\$230/\$460	\$0	\$0
Civilian Provider Copays:			
Families of E-4s and Below	\$6	15% of negotiated fees	20% of allowed charges
Other Active Duty Families	\$12	15% of negotiated fees	20% of allowed charges
Retirees and Others	\$12	20% of negotiated fees	25% of allowed charges
Civilian Inpatient Cost Shares:			
Families of E-4s and Below	\$11 per day	\$9.50 per day	\$9.50 per day
Other Active Duty Families	\$11 per day	\$9.50 per day	\$9.50 per day
Retirees and Others	\$11 per day	\$250 per day plus 20% of negotiated prof fees	\$323 per day plus 25% of negotiated prof fees

Note: This appendix shows examples of costs for families under TRICARE and does not display all cost-sharing amounts.

Appendix D: Glossary

ASD(HA) *Assistant Secretary of Defense for Health Affairs*

Balance Billing: Billing by a provider who charges more than the CHAMPUS allowable fee. By law, non-participating providers can not bill patients more than 15% above the CHAMPUS allowable charge. The patient must then pay 15% in addition to their normal cost share.

BRAC *Base Realignment and Closure Commission*

Beneficiary: Anyone eligible for military health care, including active duty/reserve/retired military personnel and their families.

CAM Catchment Area Management: A DoD project to test managed care at five military treatment facilities. A catchment area is a collection of zip codes forming a roughly 40-mile radius around each military hospital. Also referred to as a Health Service Area.

Capitation Budgeting: A method of budgeting for health care based on a certain number of dollars per person for overall care rather than on a fee for a service.

CBO *Congressional Budget Office*

CCP Coordinated Care Program: A plan to coordinate the military and civilian components of the MHSS under the auspices of the MTF commander. Active duty members would be automatically enrolled in CCP; other eligible beneficiaries could enroll on a voluntary basis.

CHAMPUS Civilian Health and Medical Program of The Uniformed Services: A cost-sharing program to pay for health care of military retirees and dependents of active duty or deceased military personnel receiving care outside the military direct delivery system.

CHAMPUS Allowable: The amount CHAMPUS regards as a fair price for a given service. It includes the government and patient cost shares.

CHAMPUS Supplemental Insurance: Health benefit plans designed to supplement CHAMPUS benefits. They generally pay most or all of whatever is left after CHAMPUS has paid its share of the costs of covered health care services and supplies.

CORM *Commission on The Roles and Missions of The Armed Forces*

CONUS *Continental United States (OCONUS Outside of the Continental United States)*

Coordinated Care: A means of using financial incentives to persuade health care providers not to order unnecessary care, patients to use providers in the system, and the health care organization to keep patients as healthy as possible (see also Managed Care).

Copayment/Copay/Cost Share: Specific dollar amounts the insured pays for certain medical services such as \$5 per prescription, or \$10 per doctor's office visit. Amount patient must pay even for care covered by CHAMPUS.

Cost-Shifting: A frequent practice by hospitals and health care providers to recoup losses sustained from providing uncompensated care to uninsured individuals by charging more to insured individuals.

CRI CHAMPUS Reform Initiative: A DoD project using contracted managed care plans to provide medical services to eligible military dependents and retirees in California and Hawaii.

Deductible: The amount that must be paid by the insured before insurance begins to pay.

Direct Care: Care given in the Military Treatment Facility (MTF) by military or civil service providers.

DoD Department of Defense

DEERS Defense Enrollment Eligibility Reporting System: Computerized data bank which lists all active and retired military members and their dependents. CHAMPUS claims processors check DEERS before processing claims to make sure patients are eligible for CHAMPUS benefits.

DHA Defense Health Agency

Eligibility: Refers to a group of individuals who, by virtue of some characteristic (age, income, race, etc.) *may* receive benefits from a particular program.

Enrollment: Signing up for TRICARE Prime. Enrollment is required and last for one year. Participants re-enroll annually.

Entitlement: Refers to individuals who, by virtue of some characteristic (age, income, race, etc.) are able to receive benefits from a program because the law mandates these individuals *will* receive these benefits.

FEHBP Federal Employees Health Benefits Program: A variety of health care plans offered to federal civil servants, their families, retirees, and survivors. The employee and the federal government contribute to the cost of the program.

Federal Health Care System: A health care system that is administered and funded by the federal government, including the Veterans Health Care System, the MHSS, the Public Health System and the Indian Health Care System among others.

GAO General Accounting Office

HBA Health Benefits Advisor: A staff member who advises patients about health care benefits.

HCF Health Care Finder: Under TRICARE, the HCF is a contractor employee who makes appointments with providers in the MTF or contractor network.

Health Care Provider: A physician, physician's assistant, nurse practitioner, nurse or other professional provider of health care.

HEW Health Education and Welfare

HMO Health Maintenance Organization: A health plan that provides care on a pre-paid, per capita basis. There are two types of HMOs: (1) group practice plans that provide benefits and services through their own medical facilities; and (2) individual practice plans that provide medical services through private offices of the plans' individual physician members and through agreements with hospitals.

JCS Joint Chiefs of Staff

Lead Agent: The commander of a DoD medical activity responsible for implementing the TRICARE health plan in one of the 12 geographic Regions.

Managed Care: A means of using financial incentives to persuade health care providers not to order unnecessary care, patients to use providers in the system, and the health care organization to keep patients as healthy as possible (see also Coordinated Care). System in which patients need not shop for their own care. PCMs act as patient advocates, monitoring all care, avoiding needless care, and referring patients to economical care sources. Such systems negotiate discounts with providers.

MCSC Managed Care Support Contracts/Contractors

Medicaid: A federally- and state-funded, state operated program that ensures the provision of medical care to low-income individuals and families.

Medicare: A federal government-supported health insurance program for people age 65 and over, people under 65 with disabilities and certain people with disabilities. A person eligible for Medicare benefits is ineligible for CHAMPUS and TRICARE.

MHSS Military Health Service System: The medical care system operated by DoD.

MTF Military Treatment Facility: Any hospital or clinic operated by the MHSS.

NAVCARE Navy Cares: A DoD program that contracts with civilian providers to provide primary care for active duty personnel, retirees, and dependents. NAVCARE clinics are found in the Navy; similar clinics in the Army and Air Force are called PRIMUS clinics.

OMB Office of Management and Budget

OASD(HA) Office of The Assistant Secretary of Defense for Health Affairs

OSD Office of The Secretary of Defense

PCM Primary Care Manager: A patients's principal provider for routine medical needs. PCMs make referrals for tests/specialty care and monitor adequacy and continuity of needed care. Usually a physician, but some are physician assistants, nurse practitioners and Independent Duty Corpsmen practicing under the supervision of a physician.

P.L. Public Law

Point of Service: An individual enrolled in TRICARE Prime may select a provider who is not within the network. However, if authorization is not obtained prior to using the non-network provider, the patient must pay 50 percent of the medical bills plus a deductible of \$300/individual or \$600/family.

PPO Preferred Provider Organization: A health plan that contracts with health care providers who provide medical care services at a lower cost to the health plan and to the patient.

PPN Preferred Provider Network: A group of civilian practitioners organized by the TRICARE contractor to supplement military direct care in TRICARE Prime and Extra. PPN members offer discounts for TRICARE users, and file patients' claims. PPN members must meet the same professional standards as MTF providers.

PRIMUS Primary Care for The Uniformed Services: A DoD program that contracts with civilian providers to provide primary care for active duty personnel, retirees and dependents. PRIMUS clinics are found in the Army and Air Force, similar clinics in the Navy are called NAVCARE clinics.

Provider: A doctor, nurse practitioner, optometrist, psychologist or other medical professional qualified to treat patients.

Subvention: A subsidy or endowment. In this case, subvention refers to an initiative that was brought before Congress in 1992 to have Medicare-eligible retirees treated in DoD and VA medical facilities with the care reimbursed by Medicare.

TRICARE Triservice Care: A DoD regional managed care program designed to improve beneficiary access to care and assure affordable and high quality care.

TRICARE Prime: One of three program options. Patients must choose to enroll in Prime. Those who choose to enroll can decide if they want to receive their care in an MTF or a civilian contracted clinic. Patients who enroll in Prime agree to use the Prime system exclusively. In turn, medical care is provided at no cost, or minimal cost.

TRICARE Extra: An option in the TRICARE Program that does not require enrollment. Patients can decide, on a case-by-case basis, to limit their care to the Preferred Provider Network. Patients have greater choice in selecting providers than with Prime. Patients who decide to use TRICARE Extra have greater out-of-pocket expense than with Prime. Annual deductibles must be met and patients have a cost share.

TRICARE Standard: An option in the TRICARE Program that does not require enrollment. This is the same as Standard CHAMPUS. Patients can decide, on a case-by-case basis, to use any CHAMPUS authorized health care provider. Patients who use TRICARE Standard also have the greatest out-of-pocket expense. Annual deductibles must be met and patients have a cost share.

TSC TRICARE Service Center: A "one-stop shopping center" for beneficiaries, operated by the TRICARE contractor. TRICARE Prime enrollment, HCF services, etc., are found here.

USC United States Code

USTF Uniformed Services Treatment Facility: A former Public Health Service hospital that has contracted with the government under P.L. 97-99 to provide medical services to all beneficiaries eligible to receive care in military treatment facilities. Available in Baltimore; Boston; Seattle; Portland; Maine; Cleveland; Houston, Galveston, Port Arthur, and Nassau Bay, Texas; and Staten Island, NY.

Utilization Review: A program that insurers use to screen hospital admissions and medical tests to cut health care costs.

VA Department of Veterans Affairs

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